California Child Health and Disability Prevention (CHDP) Program
CHDP HEALTH ASSESSMENT PROVIDER APPLICATION

IMPORTANT:

- Refer to attached instructions to complete this form.
- Type or print legibly.
- Laboratories please use the CHDP Laboratory Provider Application (DHS 4502).
- Return completed form to your local CHDP Program.

For Local CHDP Program Use Only

CHDP Program			
Address (number, street)			
City	County	State CA	ZIP code

Application for participation as *(check one)*:
(Please see instructions for description.)

☐ Comprehensive Care Provider

☐ Health Assessment Only Provider (see line 19)

Provider type *(check one)*:

☐ Solo practice ☐ Government

☐ Group practice ☐ Teaching institution

☐ Clinic *(please specify type:* _____ *)*

☐ Other *(please specify:* _____ *)*

1. Legal name of Provider Applicant

2. Business name if different from legal name

3. Social security number (SSN) *(Required if not using Federal Tax ID number) (attach copy)*

4. Business address (office/site of practice) (See instructions, **NOTE**)

Number, street City County State ZIP code

5. Business telephone number ( )

6. Fax number ( )

7. E-mail address

8. Pay-to name (last) (first) (middle initial)

9. Is the pay-to name a DBA name? ☐ Yes ☐ No

10. Federal tax ID number/ federal provider number *(Attach copy)*

11. Pay-to address

Number, street City State ZIP code

12. Type of business *(check one)*:

☐ Sole practitioner ☐ Corporation ☐ Partnership ☐ Limited liability corporation ☐ Other: _____ *(please specify)*

Principal owners

13. Active Medi-Cal provider number(s)

14. Vaccines for Children (VFC) provider number

15. Active provider in *(check all that apply)*:

☐ Medi-Cal Managed Care plans *(please specify:* _____ *)*

☐ Healthy Families plan *(please specify:* _____ *)*

☐ California Children's Services (paneled provider)

☐ Other *(please specify:* _____ *)*

16. Clinical Laboratory Improvement Amendment (CLIA) *(check one)*:

☐ CLIA waiver

☐ CLIA certificate

Certificate number

Waiver or certificate expiration date

For LOCAL CHDP PROGRAM Use Only

Reviewed by CHDP Director (print name)	Signature	Date signed	Date CHDP Provider Data Sheet (PM 177) sent to State

17. List of clinicians providing CHDP services in the office location pertaining to this application:
Please attach a copy of license and Curriculum Vitae for ***each*** clinician. Include relevant certification and/or pediatric experience in the past three years.

Name	Professional License Number	Specialty	CHDP Experience

(If more space is needed, attach additional information.)

18. Describe how you provide 24-hour on-call services. Please attach detailed description and names of clinicians providing these services.

19. Describe your provisions for any necessary hospitalizations and the name of hospital(s) used in your practice. If more space is needed, attach additional information.

20. If you are completing an application to be a Health Assessment Only Provider, please attach a detailed description of your procedures for referral to diagnosis and treatment.

21. Name of physician responsible for quality/oversight of clinical practice	22. Telephone number ( )	23. E-mail address

The Provider Applicant hereby affirms that all CHDP Clinicians meet the minimum qualification requirements as specified in the CHDP Provider Manual and have agreed to abide by the regulatory requirements and policies of the CHDP Program. The information submitted on this application and any attachments is true, accurate, and complete to the best of the Provider Applicant's knowledge and belief and are furnished in good faith. The Provider Applicant understands failure to comply with the requirements of the CHDP Program may result in disenrollment.

24. Printed name of Provider Applicant *(first)*	*(middle initial)*	*(last)*

25. Provider Applicant signature ***IN BLUE INK ONLY***	Date

Privacy Statement (as required by Civil Code, Section 1798 et seq.)

All information requested by the application is required by the Department of Health Services (DHS) by the authority of Title 17, Section 6860. The consequences of not supplying the requested information are denial of enrollment as a CHDP provider and no issuance of the provider number to obtain reimbursement from the CHDP Program. Any information provided will be used to verify eligibility to participate as a provider in the CHDP Program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by the DHS, contact the Provider Services Unit of Children's Medical Services Branch, P.O. Box 942732, Sacramento, CA 94234-7320, (916) 322-8702.

INSTRUCTIONS FOR COMPLETION OF THE
CHDP HEALTH ASSESSMENT PROVIDER APPLICATION

For assistance in completing this application, please call local CHDP Program.
Phone numbers can be found at www.dhs.ca.gov/chdp.

Health care providers wishing to enroll as a provider with the CHDP Program must complete an application packet and be approved by the local CHDP Program in order to bill the CHDP Program for CHDP services. Laboratories please use CHDP Laboratory Provider Application (DHS 4502).

Upon review and approval of the complete application, which includes an onsite facility and record review, the Provider Applicant will be assigned a provider number to use when billing the CHDP Program. Omission of any information or documentation on this application or the failure to sign this application may result in delays in processing or inability to process this application. Provider Applicants may be contacted orally or in writing if additional information and documentation are needed. A separate application must be completed if you wish to apply for participation in the CHDP Program in more than one location.

Application for participation as: Pediatricians, Family Practitioners, and Internists (for youth 14 years of age and older) or Independent Certified Family or Pediatric Nurse Practitioners, and clinics/agencies employing professionals with these qualifications may be considered for status as a Comprehensive Care or Health Assessment Only Provider (definitions from the CHDP Provider Manual). Participation as a Comprehensive Care Provider means that the Provider:

- Provides all preventive health assessment services as outlined in the CHDP Program Health Assessment Guidelines;
- Is responsible for the overall follow-up and medical case management for a child initially evaluated through the CHDP Program by initiating diagnosis, treatment, and follow-up for discovered or suspected conditions identified during the health assessment and referring to specialty care when appropriate;
- Provides families and/or patient with written summary of findings;
- Is available as the source for primary medical care, serving as a medical home, on an ongoing basis for medical services;
- Assures the availability of medical services after usual and customary office hours;
- Maintains records for each child receiving a CHDP health assessment.

Participation as a Health Assessment Only Provider means that the Provider:

- Provides all preventive health assessment services as outlined in the CHDP Program Health Assessment Guidelines;
- Documents in the child's record the referral for all children with discovered or suspected conditions identified during the health assessment needing definitive diagnosis, treatment, and follow-up services;
- Provides families and/or patient with written summary of findings;
- Provides referral/follow up report form to families and/or patient to be given to the provider(s) to whom the child has been referred for follow-up care showing the reason for referral;
- Maintains records for each child receiving a CHDP health assessment.

The CHDP Program prefers to enroll comprehensive care providers because of their ability to provide ongoing coordinated care to CHDP-eligible children as described below. Different fee schedules have been established for Comprehensive Care Providers and Health Assessment Only Providers.

Provider type: The list of types of practice associations shown on the application must meet certain license, registration, etc., requirements other than for the CHDP Program. Check the appropriate box that describes your profession or business for which you are applying to obtain a CHDP provider number in order to bill the CHDP Program. Check the "clinic" box if your type is a Hospital Outpatient Clinic, Rural Health Clinic, Community Health Clinic, Indian Health Clinic, etc., and specify what type of clinic. Identify the type of practice if the selection is "Other," such as schools. Call the office listed above if assistance is needed in determining your provider type. A separate application must be completed if you wish to apply for participation in the CHDP Program in more than one location.

1. Legal name of Provider Applicant means the name under which the Provider Applicant is applying for a CHDP provider number in the CHDP Program.
2. Business name means the name of the Provider Applicant if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the record/stamped Fictitious Business Name Statement/Permit to the application.
3. Provide the social security number of the Provider Applicant named in number 1. The social security number is not required if the Provider Applicant is using their Federal Employer Identification Number requested in item number 10. Attach a clearly legible copy of the social security card if this number is being provided.
4. Business address (office/site of practice) means the office or location where the Provider Applicant is providing services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit ZIP code. A post office box or commercial box is ***not*** acceptable. **NOTE**: Provider Applicants with multiple business addresses must complete a separate application for ***each*** business address.
5. Business telephone number means the primary business telephone number used at the Provider Applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is ***not*** acceptable as the business telephone number.
6. Fax number means the facsimile number used at this business address.

7. E-mail address means the address to which electronic communications may be sent.
8. Pay-to name means the name of the person or business to which ***payment should be issued*** by the CHDP Program for CHDP services provided by the eligible clinicians employed by the CHDP Provider. The pay-to name may be the legal name indicated in number 1, or another person or business chosen by the Provider Applicant. **NOTE:** See number 10.
9. Indicate yes or no if the pay-to name is a Doing Business As (DBA) name. If yes, the DBA name will be the name in which payment will be issued by the CHDP Program.
10. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the Provider Applicant. Attach a legible copy of IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363. If the business is a Sole Proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN, if applicable.
11. The pay-to address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit ZIP code.
12. Indicate the type of business that applies to your business structure. Provide the names of the principal owners.
13. Provide all active Medi-Cal provider number(s) of the Provider Applicant if the Provider Applicant is enrolled in the Medi-Cal Program. Provide only the active Medi-Cal provider number(s) assigned to the Provider Applicant at the address indicated on this form.
14. Provide the Vaccines for Children (VFC) provider number if the Provider Applicant is enrolled in the VFC Program.
15. Identify in which health care plans the Provider Applicant is a provider, e.g., Medi-Cal Managed Care, Healthy Families Plan, or other children's health insurance programs.
16. Identify if your office location has a CLIA waiver or certificate by checking one of the boxes. Provide the certificate number if the office location has a CLIA certificate and the expiration date of the CLIA waiver or certificate.
17. Identify the names, professional license numbers, specialty, and location and length of CHDP experience for the clinicians in your office delivering CHDP comprehensive preventive examinations to children and youth up to age 21 years.
18. Describe how your practice provides 24-hour on-call services to the clients seen at the office address of this application. Include the names of the clinicians providing these services.
19. Describe how you arrange for hospitalizations of clients needing admission and the names of the hospitals used in your practice.
20. If you are applying to be a Health Assessment Only Provider, describe your procedures for referral to diagnosis and treatment.
21. Name the physician responsible for oversight of the quality of clinical practice within the entity.
22. Provide the telephone number for the person named in number 21.
23. Provide the e-mail address for the person named in number 21.
24. Pint the first name, middle initial, and last name of the Provider Applicant indicated in number 1.
25. Provider Applicant signature means the first name, middle initial, and last name of the Provider Applicant indicated in number 1. An original signature ***IN BLUE INK ONLY*** is required. Indicate the date the application is signed. **NOTE:** Provider Applicant signature on the CHDP Health Assessment Provider Program Agreement (DHS 4491) means the name and title of the Provider Applicant indicated in number 1 of the CHDP Health Assessment Provider Application (DHS 4490). An original signature is required. Indicate the date the program agreement is signed.

Did you remember to enclose (as applicable):

- ☐ The original, signed CHDP Health Assessment Program Provider Agreement (DHS 4491)
- ☐ Copy of FEIN or ITIN verification, or social security card, if applicable
- ☐ Copy of Fictitious Business Name Statement/Permit, if applicable
- ☐ Copy of professional licenses, relevant certifications, and curriculum vitae for all clinicians providing CHDP services
- ☐ Description of 24-hour coverage arrangements
- ☐ Description of arrangements for hospitalizations, if applicable
- ☐ Description of referral procedures for diagnosis and treatment, if applicable
- ☐ Other, if applicable

Send completed form to your local CHDP Program. If not indicated on page 1, mailing addresses may be found at **www.dhs.ca.gov/chdp**.